STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MI	JLTIPLE CO	ONSTRUCTION	(X3) DATE S		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	01	COMPL	
		155159	B. WIN	G		01/31/	2013
NAME OF P	ROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE		
					CLINTON ST		
SUMMIT	CITY NURSING A	ND REHABILITATION		FORT	WAYNE, IN 46805		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG K0000	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)	Į.	DATE
KUUUU							
	A Life Safety C	ode Recertification, State	K00	000	The creation and submission	'n	
	_	ey and the Preoccupanciy	1100		of this Plan of Correction do		
		addition of 5 title 18 SNF			not constitute an admission		
		to rooms 115, 117, 119,			this provider of any conclus	-	
		s conducted by the			set forth in the statement of		
		epartment of Health in			deficiencies, or of any		
		1 42 CFR 483.70(a).			violation of regulation.		
	accordance with	142 CFR 483.70(a).					
	G D. (0	1/21/12			This provider respectfully		
	Survey Date: 0	1/31/13			requests that the 2567 Plan		
	T 111. 37. 1	000070			Correction be considered th		
	Facility Number				Letter of Credible Allegation	1.	
	Provider Number				This facility respectfully requests a revisit on or afte	r	
	AIM Number:	100266160			March 2, 2013.	•	
	Curvayar: Am	Kelley, Life Safety Code					
	Specialist Specialist	Kelley, Life Safety Code					
	Specialist						
	At this Life Safe	ety Code and					
	Preoccupancy s	urvey, Summit City					
		habilitation was found not					
		vith Requirements for					
	_	Medicare/Medicaid, 42					
	•	33.70(a), Life Safety from					
	•	00 edition of the National					
		Association (NFPA) 101,					
		le (LSC), Chapter 19,					
		Care Occupancies and					
	_	.1-19, Environment and					
		rds of the Indiana Health					
		for Comprehensive care					
	facilities.						

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	01	COMPLETED
		155159	B. WING		01/31/2013
NAME OF F	PROVIDER OR SUPPLIEI	R		T ADDRESS, CITY, STATE, ZIP CODE	
				N CLINTON ST	
SUMMIT	CITY NURSING A	ND REHABILITATION	FOR	T WAYNE, IN 46805	
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	` `	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR	IATE CONTINUE TO I
TAG		R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
		acility with a basement			
		to be of Type II (111)			
		l was fully sprinklered.			
	_	a fire alarm system with			
		in the corridor, areas			
	_	idor and battery operated			
		in the resident rooms.			
	_	a capacity of 88 and had a			
	census of 69 at t	the time of this survey.			
	All areas where	the residents have			
	customary acces	ss are sprinklered. The			
	facility does hav	ve a shed providing			
	facility services	that was not sprinklered.			
		Robert Booher, Life Safety			
	Code Specialist-Me	edical Surveyor on 02/06/13.			
	_	found not in compliance			
		entioned regulatory			
	•	evidenced by the			
	following:				

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155159 NAME OF PROVIDER OR SUPPLIER SUMMIT CITY NURSING AND REHABILITATION		(X2) MU A. BUII B. WIN	LDING G STREET A 2940 N	NSTRUCTION 01 ADDRESS, CITY, STATE, ZIP CODE CLINTON ST VAYNE, IN 46805	(X3) DATE S COMPLI 01/31/	ETED	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
K0017 SS=E	walls constructed resistance rating. partitions are only passage of smok buildings, walls p ceiling. (Corridor underside of ceiling permitted by Cod stations, waiting a activity spaces m under certain con Code. Gift shops corridors by nonshop is fully sprin 19.3.6.2.1, 19.3.6. Based on observ facility failed to floor west wing separated from the capable of resists as required in a smet an Exception # 6, S sleeping rooms, hazardous areas corridor and unlifulation (a) The space an space opens onto compartment are electrically super detection system protected by an a (c) The space is	with at least ½ hour fire In sprinklered buildings, verequired to resist the e. In non-sprinklered roperly extend above the walls may terminate at the ngs where specifically e. Charting and clerical areas, dining rooms, and ay be open to the corridor ditions specified in the may be separated from fire rated walls if the gift klered.) 19.3.6.1, 6.5 ation and interview, the ensure 1 of 1 second dining rooms was the corridors by a partition ing the passage of smoke sprinklered building, or n. LSC 19-3.6.1, paces other than patient treatment rooms, and may be open to the mited in area provided: d corridors which the on the same smoke	K00	017	K 017 NFPA 101 Life Safet Code Standard It is the practice of this facili to ensure that all areas ope to the corridors are supervised automatic smoke detection system. However, based of the alleged deficient practice the following has been implemented: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: The battery operated smoke detector will be replaced. The electrically	ty n sed on e	03/02/2013

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Event ID: 1DLO21

Facility ID: 000079

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	IULTIPLE CC	ONSTRUCTION	(X3) DATE S	URVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	01	COMPLE	ETED
		155159	B. WIN			01/31/2	2013
			D. WII		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIE	R			CLINTON ST		
CLIMANIT	CITY NILIDOING A	ND REHABILITATION			WAYNE, IN 46805		
SOMM	CITT NURSING A	ND REHABILITATION		FORT	WATNE, IN 40805		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	practice could a	ffect any of the 15 west			supervised automatic smok	e	
	wing second flo	or residents.			detection system was instal	led	
					on 2-8-13.		
	Findings include	··					
	Tilldings illelude	.			How will you identify other	er	
					residents having the		
	Based on an obs	servation with the			potential to be affected by		
	Maintenance Su	pervisor on 01/31/13 at			the same deficient practice		
	12:54 a.m., the s	second floor west wing			and what corrective action		
	1	ked corridor doors and			will be taken:	•	
	_	corridor. Furthermore,			will be takell.		
		equirement (a) of the LSC			All regidents because the		
		• • • • • • • • • • • • • • • • • • • •			All residents have the		
		was not met because the			potential to be affected by the	ne	
	second floor we	st wing dining room was			alleged deficient practice.		
	not protected by	an electrically supervised			Ensure all areas oper		
		e detection system. The			to the corridors are supervis	sed	
		pervisor confirmed the			by electrically supervised		
		in the second floor west			automatic smoke detection		
					system.		
		m was battery operated by					
	removing the de	evice from the wall.			What measures will be put	t	
					into place or what systemi	ic	
	3.1-19(b)				changes will you make to		
	. ,				ensure that the deficient		
					practice does not recur:		
					The battery operated		
					smoke detector will be		
					replaced. The electrically		
					supervised automatic smok	_	
					detection system was instal		
					on February 8, 2013.		
					The Maintenance		
					Director or Designee will		
					_		
					check all areas open to the		
					corridors are supervised by		
					electrically supervised		

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155159	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 01/31/2013
	PROVIDER OR SUPPLIED	ND REHABILITATION	2940 N	ADDRESS, CITY, STATE, ZIP CODE I CLINTON ST WAYNE, IN 46805	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES SICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	Ditte
				automatic smoke detection system by March 2, 2013. The Maintenance Director is in charge of program compliance	
				How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:	y
				A CQI monitoring too called Smoke Detector Aud will be utilized monthly x 3 quarterly x 2. Data will be collected Maintenance Director/Designee and submitted to the CQI committee. If threshold of 100% is not met, an action plan will be developed. Non-compliance with facility procedures may resin disciplinary action up to a including termination.	lit and d by ult
				Completion Date: 3/2/13	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			JRVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 01 COMPLETED			ΓED	
		155159			01/31/2013		
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER						
CLIMANAIT		ND REHABILITATION			CLINTON ST WAYNE, IN 46805		
SOIVIIVII I	CITT NORSING AI	ND REHABILITATION		FORT	WATNE, IN 40805		
(X4) ID				ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP		TE '	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
K0038	NFPA 101	DE 074104DD					
SS=E	LIFE SAFETY CO						
		anged so that exits are eat all times in accordance					
	with section 7.1.						
		ervation and interview,	K00	38	K 038 NFPA 101 Life Safet	.	03/02/2013
		I to ensure 1 of 3 second			Code Standard	y	05/02/2015
	_				It is the practice of this facili	ity	
		rge paths was readily			to ensure all exit discharge	ity	
		times. This deficient			paths are readily accessible	at l	
	-	fect 15 residents in the			all times. However, based		
	west wing on the	e second floor.			the alleged deficient practic		
					the following has been		
	Findings include	:			implemented:		
					Implemented.		
	Based on observ	ation with the			What corrective action(s)		
		pervisor on 01/31/13 at			will be accomplished for		
		vest wing exit stairway			those residents found to		
	-	- · · · · · · · · · · · · · · · · · · ·			have been affected by the		
	_	ock did not release when			deficient practice:		
		Supervisor entered the			deficient practice.		
	•	sted near the door. The			The facility repaired t	he	
	_	pervisor acknowledged			code box on February 8,		
	the door did not	release with any entry			2013.		
	into the keypad b	out did release upon			PUSH UNTIL ALARI	м І	
	activation of the	fire alarm system.			SOUNDS DOOR CAN BE		
					OPENED IN 15 SECONDS	,,	
	3.1-19(b)				sign, with letters 1 inch high	l l	
	(-)				and not less than 1/8 inch in		
	2. Based on obs	ervation and interview,			width, was installed on the		
		I to ensure 1 of 3 second			east wing egress door.		
	_	was accessible. Health					
		s permit delayed egress			How will you identify othe	r	
		onditions of LSC, Section			residents having the		
					potential to be affected by	,	
		LSC 7.2.1.6(d) requires			the same deficient practic		
		cent to the release device			and what corrective action		
	there shall be a r	eadily visible, durable			will be taken:		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	а. вил	LDING	01	COMPLI	ETED
		155159	B. WIN			01/31/	2013
NAME OF I	PROVIDER OR SUPPLIER)	•	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					CLINTON ST		
SUMMIT	CITY NURSING AI	ND REHABILITATION		FORT V	VAYNE, IN 46805		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE
1710		et less than 1 inch high		1110			BATE
	1 -	1/8 inch in width on a			· All residents have the	e	
		ground that reads as			potential to be affected by t	he	
	_	I UNTIL ALARM			alleged deficient practice.		
		R CAN BE OPENED IN			 All exit discharge pat 	hs	
		This deficient practice			will be audited on or before		
		•			March 2 nd 2013 to ensure		
		residents in the east wing			readily accessibility at all		
	on the second flo	oor.			times.		
					· All egress doors will l	oe	
	Findings include	: :			audited to ensure proper		
					signage on or before March 2013.	1 2,	
	Based on observ				2013.		
		pervisor on 01/31/13 at			What measures will be put	.	
	1:17 p.m., the se	econd floor east wing exit			into place or what system		
	door was equipp	ed with electromagnetic			changes you will make to		
	locks that release	ed after pushing the door			ensure that the deficient		
	for 15 seconds b	ut it lacked the proper			practice does not recur		
	signage. Based	on an interview with the			praemee accessors		
	Maintenance Su	pervisor at the time of			· All exit discharge pat	hs	
	observation, he	was not aware the exit			will be audited on or before		
	door was set up	with a delayed egress			March 2 nd 2013 to ensure		
	locking system.	, ,			readily accessibility at all		
					times.		
	3.1-19(b)				· All egress doors will l	be	
					audited to ensure proper		
					signage on or before March	12,	
					2013.		
					The Maintenance Director/Designee will		
					in-service the management		
					team to immediately report		
					any issues with the exit doc	r l	
					codes obstructing the ability		
					open the door and/or prope		
					signage.		

	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER: 155159	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 01/31/2013
	PROVIDER OR SUPPLIER CITY NURSING AND REHABILITATION	2940 N	ADDRESS, CITY, STATE, ZIP CODE CLINTON ST WAYNE, IN 46805	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
			The Maintenance Director is in charge of program compliance	
			How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: A CQI monitoring too called Egress Door Audit (Code and Signage) will be utilized every month x 3 and quarterly x 2. Data will be collected Maintenance Director/Designee and submitted to the CQI committee. If threshold of 100% is not met, an action plan will be developed. Non-compliance with facility procedures may resin disciplinary action up to a including termination. Completion date: 03/02/2013	y e ol d by of

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155159			(X2) MULTIPLI A. BUILDING B. WING	E CONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 01/31/2013
	PROVIDER OR SUPPLIEF	ND REHABILITATION	2940	ET ADDRESS, CITY, STATE, ZIP CODE O N CLINTON ST RT WAYNE, IN 46805	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE
K0062 SS=E	continuously mai condition and are periodically. 18 NFPA 25, 9.7.5 Based on observe facility failed to for sprinkler hear were unobstructed automatic sprink tested and maint NFPA 25, Stand Testing and Mai Fire Protection Section 2-2.1.2 sobstructions to secorrected. This affect 4 residents Findings included Based on observe Maintenance Su 2:05 p.m., three Cottage spa were top to bottom of was mounted neithe sprinkler hear providing covera stall. This was a second conditional and are provided to the sprinkler hear providing covera stall. This was a second conditional and the sprinkler hear providing covera stall. This was a second conditional and the sprinkler hear providing covera stall. This was a second conditional and the sprinkler hear providing covera stall. This was a second conditional and the sprinkler hear providing covera stall. This was a second conditional and the sprinkler hear providing covera stall. This was a second conditional and the sprinkler hear providing covera stall. This was a second conditional and the sprinkler hear providing covera stall. This was a second conditional and the sprinkler hear providing covera stall. This was a second conditional and the sprinkler hear providing covera stall.	tic sprinkler systems are intained in reliable operating inspected and tested 0.7.6, 4.6.12, NFPA 13, ation and interview, the ensure the spray pattern ds in 1 of 1 Cottage spased. LSC 9.7.5 requires all the systems be inspected, ained in accordance with ard for the inspection, intenance of Water-Based Systems. NFPA 25, states unacceptable pray patterns shall be deficient practice could state.	K0062	K 062 NFPA 101 Life Safety Code Standard It is the prace of this facility to ensure autor sprinkler systems are continuously maintained in reliable operating condition a are inspected and tested periodically. However, based the alleged deficient practice following has been implement What corrective action(s) w be accomplished for those residents found to have bee affected by the deficient practice: The plastic solid shower curtain from top to be in the Cottage Spa was remo on 2-1-13. How will you ider other residents having the potential to be affected by the same deficient practice and what corrective action will the taken: Residents residing of the cottage have the potential be affected by the alleged deficient practice. All Spans shower stalls will be checked maintenance staff on or before March 2, 2013 to ensure spris systems are continuously maintained in reliable operatic condition. What measures we	natic nd d on the the ted: iii en ottom oved ntify he oe on al to oom l by re nkler ng

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	OF CORRECTION IDENTIFICATION NUMBER: 155159	(X2) MULTIPLE CO A. BUILDING B. WING	01	(X3) DATE SURVEY COMPLETED 01/31/2013
	PROVIDER OR SUPPLIER CITY NURSING AND REHABILITATION	2940 N	ADDRESS, CITY, STATE, ZIP CODE CLINTON ST WAYNE, IN 46805	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	3.1-19(b)		be put into place or what systemic changes you will make to ensure that the deficient practice does not recur: The plastic solid sho curtain from top to bottom in to Cottage Spa was removed or 2-1-13. The Maintenance Director/Designee will in-serv Department Heads on sprinkl head obstruction and monitor on or by March 2, 2013. The Maintenance Director is in chof program compliance How corrective action(s) will be monitored to ensure the deficient practice will not rei.e., what quality assurance program will be put into place. A CQI monitoring tool called Sprinkler Head Inspection will utilized every month x 3 and every quarter x 2. Data will collected by Maintenance Director/Designee and submit to the CQI committee. If threshold of 100% is not met, action plan will be developed. Non-compliance with facility procedures may result in disciplinary action up to and including termination. Completion date: 03/02/201	the ice er ing ne arge the cur, ce: d I be be tted an

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Event ID: 1DLO21

Fac

Facility ID: 000079

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155159			LDING	ONSTRUCTION 01	(X3) DATE S COMPL 01/31 /	ETED	
	PROVIDER OR SUPPLIER	ID REHABILITATION		2940 N	ADDRESS, CITY, STATE, ZIP CODE CLINTON ST WAYNE, IN 46805		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
K0064 SS=D	health care occup 9.7.4.1. 19.3.5. Based on observe facility failed to portable fire exti- cooking area in a requirements of 1 Portable Fire Ext NFPA 10, 2- 3.2 extinguishers pro- of cooking applia cooking media (v and fats) shall be Class K fires. N a placard shall be near the extingui- protection system to using the fire of fixed fire extingu- automatically should be activate portable fire exti- instance, the port- supplemental pro- practice was not could affect any	guishers are provided in all pancies in accordance with 6, NFPA 10 ation and interview, the maintain 1 of 1 K-Class inguishers in the kitchen accordance with the NFPA 10, Standard for cinguishers, 1998 Edition. requires fire evided for the protection ances use combustible are conspicuously placed sher which states the fire in shall be activated prior extinguisher. Since the aishing system will at off the fuel source to itance, the fixed system are defined as a neguisher. In this table fire extinguisher is officient in a resident care area by number of kitchen staff.	K00	064	K 064 NFPA 101 Life Safer Code Standard It is the practice of this facil to ensure K-Class portable extinguishers are labeled wa placard. However, base on the alleged deficient practice the following has been implemented: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: The appropriate placard be professionally posted by the K-Class Fire Extinguish in the kitchen on 2-18-13. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken All staff in the kitcher have the potential to be effected by the alleged deficient practice. All fire extinguishers	lity fire vith d will reer	03/02/2013

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Event ID: 1DLO21

Facility ID: 000079

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	OF CORRECTION OF CORRECTION 155159	(X2) MULTIPLE CO A. BUILDING B. WING	01	(X3) DATE SURVEY COMPLETED 01/31/2013
	PROVIDER OR SUPPLIER CITY NURSING AND REHABILITATION	2940 N	ADDRESS, CITY, STATE, ZIP CODE CLINTON ST NAYNE, IN 46805	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
TAG	2:32 p.m., the kitchen K-Class fire extinguisher lacked a placard. Based on an interview with the Maintenance Supervisor at the time of observation, the kitchen K-Class fire extinguisher lacked a placard identifying its use as secondary backup to the kitchen fire suppression system. 3.1-19(b)	TAG	be checked by maintenance staff on or before March 2, 2013 to ensure appropriate signage. What measures will be purinto place or what system changes you will make to ensure that the deficient practice does not recur All fire extinguishers be monitored on an on-goin basis to ensure appropriate signage by Maintenance Director/ Designee. The Maintenance Director/Designee will in-service management teat on the appropriate signage and monitoring of fire extinguishers by March 2, 2013. The Maintenance Director is in charge of program compliance	t ic will ag
			How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: A CQI monitoring too called Fire Extinguisher Auwill be utilized monthly x 3 and a control of the control	re / in the second of the se

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/20/2013 FORM APPROVED OMB NO. 0938-0391

		IDENTIFICATION NUMBER: 155159	A. BUILDING B. WING	01	COMPLETED 01/31/2013		
NAME OF PROVIDER OR SUPPLIER SUMMIT CITY NURSING AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 2940 N CLINTON ST FORT WAYNE, IN 46805				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
				quarterly x 2. Data will be collected Maintenance Director/Designee and submitted to the CQI committee. If threshold of 100% is not met, an action plan will be developed. Non-compliance with facility procedures may rest in disciplinary action up to a including termination. Completion date: 03/02/2013	ult		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE S	ATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		a. Building 01			COMPLE	COMPLETED	
155159		B. WIN			01/31/2	2013	
			D. 1111		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				CLINTON ST		
SUMMIT	CITY NURSING AN	ND REHABILITATION			WAYNE, IN 46805		
(X4) ID	CLIMMA DV C	TATEMENT OF DEFICIENCIES			T		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL	ID PREFIX		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	*	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIADEFICIENCY)	ΓE	DATE
K0069	NFPA 101	ESC IDENTIFY TING INFORMATION)		IAG		-	DATE
SS=D	LIFE SAFETY CO	ODE STANDARD					
33-D	Cooking facilities						
		9.2.3. 19.3.2.6, NFPA 96					
		review and interview, the	K00	069	K 069 NFPA 101 Life Safet	v I	03/02/2013
		ensure 1 of 1 kitchen			Code Standard	,	
	_	was maintained in proper			It is the practice of this facili	_{itv}	
	_	* *			to ensure the kitchen exhau	,	
	_	NFPA 96, 10-6.5 requires			system is inspected and	~`	
	inspection and te	•			tested of the total operation		
	•	safety interlocks in			and all safety interlocks in		
	accordance with	the manufacturer's			accordance with the		
	instructions shall	l be performed by			manufacturer's instructions		
	qualified service	personnel a minimum of			shall be performed by		
	-	nths or more frequently if			qualified service personnel	a	
		eficient practice was not			minimum of once every six	<u> </u>	
	•	but could affect kitchen		months or more frequently if		f	
		tout could affect kitchen			required. However based or		
	staff.				the alleged deficient practic		
					the following has been		
	Findings include				implemented:		
	Based on record	review with the			What corrective action(s)		
	Maintenance Sup	pervisor on 01/31/13 at			will be accomplished for		
	1:58 p.m., the 36	0 Degree Services			those residents found to		
		aning report titled			have been affected by the		
		' dated 10/08/12 stated			deficient practice:		
	•	luctwork from kitchen					
					On February 5, 2013, 36	o	
		or is screwed on and			Services installed an access		
	•	accessible area exist: All			door and inspected and		
		ned all accessible areas of			cleaned the kitchen exhaus	t l	
	-	" Based on an interview			system.		
	with the Mainter	nance Supervisor at the					
	time of record re	view, he confirmed the			How will you identify other	r	
	inaccessible area	s were not properly			residents having the		
	cleaned.				potential to be affected by		
					the same deficient practic		
			- 1				

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155159	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 01/31/2013
	PROVIDER OR SUPPLIE	R ND REHABILITATION	STREET . 2940 N	ADDRESS, CITY, STATE, ZIP CODE CLINTON ST WAYNE, IN 46805	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	3.1-19(b)			and what corrective action will be taken:	n
				the potential to be effected the alleged deficient practic. Executive Director in-serviced the Maintenance Department on how to ensure there is not a blockage in the kitchen exhaust system that will interfere with cleaning. What measures will be purinto place or what system changes you will make to ensure that the deficient practice does not recur: The kitchen exhaust system will be monitored on an on-going basis to ensure cleaning and inspections at happening every 6 months contact with 360 Services. Maintenance Director is responsible for program compliance.	by be. e cure ne ot t ic tem
				will be monitored to ensu the deficient practice will not recur, i.e., what qualit assurance program will be put into place: The kitchen exhaust	y e

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PRINTED: 02/20/2013 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155159	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 01/31/2013		
NAME OF PROVIDER OR SUPPLIER SUMMIT CITY NURSING AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 2940 N CLINTON ST FORT WAYNE, IN 46805				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE COMPLETION DATE		
				system will be monitor an on-going basis to e cleaning and inspection happening every 6 months the preventative mainty book per contact with Services. Non-compliance facility procedures main disciplinary action unincluding termination. Completion date: 03/02/2013	ensure ons are onths by tenance 360 e with y result		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY	
│ 155150		A. BUII	DING	01	COMPL	OMPLETED	
		B. WIN			01/31/	2013	
NAME OF B	DOLUBED OF GUIDNIED			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER			2940 N	CLINTON ST		
	CITY NURSING AN	ND REHABILITATION		FORT V	VAYNE, IN 46805		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION
TAG	NFPA 101	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCI)		DATE
K0143 SS=E	LIFE SAFETY CO	ODE STANDARD					
35-L	Transferring of ox						
	3	33-					
		n any portion of a facility					
	•	are housed, examined, or					
	1-hour fire-resistiv	ration of a fire barrier of					
	1-110ul III-lesisti	ve construction,					
	(b) in an area that	t is mechanically ventilated,					
	•	nas ceramic or concrete					
	flooring; and						
	(c) in an area nos	sted with signs indicating					
		s occurring, and that					
	smoking in the im	mediate area is not					
	•	rdance with NFPA 99 and					
	the Compressed	Gas Association.					
	8.6.2.5.2		VO1	12	K 440 NEDA 404 Life O-f-4		03/02/2013
	Based on obser		K0143		K 143 NFPA 101 Life Safety		03/02/2013
	interview, the f	•			Code Standard		
	ensure 1 of 1 a				It is the practice of this facili	tv	
	transferring of	• •			to ensure oxygen is in an ar	-	
	provided with o				that is mechanically ventilat		
	mechanical ver				However, based on the		
	deficient practi				alleged deficient practice the	е	
	residents in the	e second floor			following was implemented:		
	dining room wl	hich has a seating					
	capacity of 28	residents.			What corrective action(s)		
					will be accomplished for		
	Findings includ	le:			those residents found to		
					have been affected by the		
	Based on obser	rvation with the			deficient practice:		
	Maintenance Su	upervisor on			· The switch in the		
	01/31/13 at 12	•			oxygen room was removed		
	mechanical ver	-			and the exhaust fan was		
	second floor o				rewired to provide continuou	ıs	
	Second Hoor O	Aygen				40	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIP	LE CO	NSTRUCTION	(X3) DATE		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155159		A. BUILDING	ĵ	01	COMPL 01/31/		
100100			B. WING			01/31/	2013
NAME OF P	ROVIDER OR SUPPLIEF	R			ADDRESS, CITY, STATE, ZIP CODE		
SUMMIT	CITY NURSING A	ND REHABILITATION			CLINTON ST VAYNE, IN 46805		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREF	IX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ιΤΕ	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAC	G	DEFICIENCY)		DATE
	transfilling/sto	rage room which			ventilation on 2-1-13.		
	contained at le	ast four large				_	
	stationary cont	tainers of liquid			How will you identify othe	r	
	oxygen was co	ntrolled by an			residents having the		
	electrical wall s	switch. The oxygen			potential to be affected by		
		ocated near the			the same deficient practic and what corrective action		
	_	ining room was			will be taken:	•	
	identified with				mii bo takeii.		
		a. At the time of			· All residents have the	е	
	_				potential to be affected by t		
	observation, the Maintenance Supervisor turned the wall switch				alleged deficient practice.		
		tion confirming the			· All oxygen rooms wil	l be	
	-	trol the mechanical			checked by the Maintenand	e	
					Department on or before		
		the oxygen storage			March 2, 2013 to ensure		
	room.				mechanical ventilation.		
	3.1-19(b)				What measures will be pu	t	
					into place or what system		
					changes you will make to		
					ensure that the deficient		
					practice does not recur:		
					· All oxygen rooms wil	ı be	
					monitored on an on-going		
					basis to ensure continuous mechanical ventilation.		
					The Maintenance		
					Director/Designee will		
					in-service all managers tha	t	
					the exhaust fan was rewire		
					provide continuous ventilati	on	
					March 2, 2013.		
					· The Maintenance		
					Director is in charge of		
					program compliance.		
			1				I

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED	
		155159	B. WING		01/31/2013
	PROVIDER OR SUPPLIE	R ND REHABILITATION	2940 N	ADDRESS, CITY, STATE, ZIP CODE I CLINTON ST WAYNE, IN 46805	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: - A CQI monitoring too called Oxygen Room Audit be utilized monthly x 3 and quarterly x 2. - Data will be collected Maintenance Director/Designee and submitted to the CQI Committee. If threshold of 100% is not met, an action plan will be developed. - Non-compliance with facility procedure may resuld disciplinary action up to and including termination. Compliance date: 03/02/2013	(s) re / e ul will I by

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AND PLAN	IT OF DEFICIENCIES OF CORRECTION PROVIDER OR SUPPLIER	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155159		LDING G STREET	ONSTRUCTION 01 ADDRESS, CITY, STATE, ZIP CODE	(X3) DATE S COMPLI 01/31/	ETED
SUMMIT	CITY NURSING AN	ID REHABILITATION	2940 N CLINTON ST FORT WAYNE, IN 46805				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
K0147 SS=D	accordance with I Electrical Code. 9 Based on observe facility failed to cords was not us fixed wiring to p equipment. NFF Code, 1999 Edition requires, unless of flexible cords and as a substitute for structure. This diffect 1 of 16 east residents. Findings include Based on observe Maintenance Supplied with electron grower stript the second floor.	and equipment is in NFPA 70, National 1.1.2 ation and interview, the ensure 1 of 1 flexible ed as a substitute for rovide power for medical PA 70, National Electrical fon, Article 400-8 specifically permitted, d cables shall not be used a fixed wiring of a seficient practice could st hall second floor	K01	47	K 147 NFPA 101 Miscellaneous It is the practice of this facil to ensure flexible cords are not used as a substitute for fixed wiring. However, bas on the alleged deficient practice the following was implemented: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: The extension cord power strips in room 217 w removed from the building on1-31-13. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All residents have the potential to be affected by the same deficient practice. All residents have the potential to be affected by the same deficient practice. All residents have the potential to be affected by the same deficient practice. All rooms will be checked on or before Marce	e ded ded de	03/02/2013

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	OF CORRECTION	IDENTIFICATION NUMBER: 155159	(X2) MULTIPLE CO A. BUILDING B. WING	01	COMPLETED 01/31/2013
NAME OF P	PROVIDER OR SUPPLIER	<u> </u>	STREET 2940 N	ADDRESS, CITY, STATE, ZIP CODE	1
SUMMIT	CITY NURSING A	ND REHABILITATION	FORT	WAYNE, IN 46805	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	E COMPLETION
				2013 to ensure no flexible cords are being used as a substitute for fixed wiring operation medical equipments.	ı to
				What measures will be p into place or what system changes you will make to ensure that the deficient practice does not recur:	mic o
				All rooms will be monitored on an on-going basis to ensure no flexible cords are being used as a substitute for fixed wiring the Maintenance Director. The Maintenance Director/Designee will in-service all managers or prohibited use of flexible of being used as a substitute fixed wiring by March 2, 2 The Maintenance Director is in charge of program compliance	e by by the cords e for
				How the corrective actio will be monitored to ensithe deficient practice will not recur, i.e., what qualitassurance program will put into place: A CQI monitoring to called Flexible Wiring will utilized weekly x 4, month	ure I ity be

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	OF CORRECTION	IDENTIFICATION NUMBER: 155159	A. BUILDING B. WING	01	COMPL 01/31	LETED
	PROVIDER OR SUPPLIE	R ND REHABILITATION	STREET . 2940 N	ADDRESS, CITY, STATE, ZIP CODE CLINTON ST WAYNE, IN 46805		
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROI DEFICIENCY)	ON BE PRIATE	(X5) COMPLETION DATE
				3 and quarterly x 2. Data will be collect Maintenance Director/Designee and submitted to the CQI Committee. If threshold of 100% is not met, an action plan will be developed. Non-compliance we facility procedure may re disciplinary action up to a including termination. Compliance date: 03/02/2013	of on vith sult in	

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